

MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Ronald Reagan Building  
International Trade Center  
Horizon Ballroom  
1300 13th Street, N.W.  
Washington, D.C.

**Thursday, March 21, 2002**  
**10:10 a.m.**

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair  
ROBERT D. REISCHAUER, Ph.D., Vice Chair  
BEATRICE S. BRAUN, M.D.  
AUTRY O.V. "PETE" DeBUSK  
ALLEN FEEZOR  
FLOYD D. LOOP, M.D.  
RALPH W. MULLER  
ALAN R. NELSON, M.D.  
JOSEPH P. NEWHOUSE, Ph.D.  
JANET G. NEWPORT  
CAROL RAPHAEL  
ALICE ROSENBLATT  
JOHN W. ROWE, M.D.  
DAVID A. SMITH  
RAY A. STOWERS, D.O.  
MARY K. WAKEFIELD, Ph.D.

**AGENDA ITEM: Beneficiaries' access to Medicare hospice care**  
**-- Sally Kaplan**

DR. KAPLAN: Good afternoon. We're going to talk about access to hospice in this session, as Glenn said. In BIPA, the Congress requested we study to access to and use of hospice. They asked us to pay special attention to delay in the use of hospice, and urban and rural differences in use. The BIPA language is in an appendix to your mailing material.

As you know, access is a multidimensional concept. In this study we used two indicators of access: beneficiaries use of services and supply of providers. We also hired a contractor, Jay Mahoney, to interview individuals knowledgeable about hospice so we could learn about access problems not detected by these two indicators.

As you also know, hospice has a relatively rich group of services, some of which Medicare does not pay for in other settings. For example, Medicare does not pay for drugs or homemaker services under home health care. To be eligible for hospice services beneficiaries must have two physicians certify that their life expectancy is six months or less, and beneficiaries must give up curative care for the terminal condition.

As promised in your mailing material, we have updated most of the data to 2000 thanks to the hard work of Chris Hogan. We'll update the rest for April's meeting. At the end of the presentation we'll ask you for your comments, and of course, questions.

As you can see from the figure on the screen and in your handouts, the number of beneficiaries using hospice tripled from 1992 to 2000. During this time period the number of hospices almost doubled. In 1998, 20 percent of Medicare decedents used hospice. In that year, cancer patients using hospice accounted for 51 percent of all beneficiaries who died of cancer. Cancer patients are the lighter part of each bar in the figure.

The beneficiaries with the greatest growth in hospice use were those with non-cancer diagnoses -- the black part of each bar in the figure -- those living in nursing homes or living in rural areas. Only 2 percent of beneficiaries lived in areas with no hospice services available in 1998.

The empirical evidence shows that minority beneficiaries use hospice less than their white counterparts. It also shows that beneficiaries without supplemental insurance coverage use hospice less than those with any type of secondary insurance, including M+C. These findings could indicate access problems for these two groups, but the lower use could be due to other reasons.

The literature suggests that cultural differences are largely responsible for lower use by minorities. However, no simple explanation exists for beneficiaries without secondary insurance, especially because there is very little cost-sharing for hospice services. People without secondary insurance are disproportionately low income and non-white. But Chris

controlled for income and race in the regression analysis, so this is an independent effect.

The hospice community believes that four other groups of beneficiaries have difficulty accessing hospice, but there may be other explanations. Two of these groups, nursing home residents and beneficiaries with non-cancer diagnoses, experienced the greatest growth in hospice use, as we said before. Older-old beneficiaries frequently do not have caregivers and some hospices will not admit individuals without them.

Regarding patients using chemotherapy, radiation or surgeries, on the one hand we have that some hospices won't admit these beneficiaries. On the other hand, some patients using these interventions may not have accepted the proximity of their death or be willing to give up curative care.

Some believe that short hospice stays are also an indicator of access problems. The fraction of hospice patients dying within one week of admission increased from 21 percent in 1992 to 30 percent in 2000. We're not sure what this increase means given the change in the population during this period.

Main causes of late referrals, however, appear to be difficulty of making prognoses, beneficiaries unwillingness to give up curative care, and the greater availability of non-toxic therapies. The literature documents the difficulty that physicians have making prognoses of death within six months. Only 20 percent of the diagnoses are accurate. Sixty-three percent over-estimate survival time.

Even when physicians identify patients as eligible for hospice, patients may choose to continue curative care. The greater availability of therapies that are not debilitating may result in more beneficiaries delaying election of hospice. As you heard this morning from Dr. Hurley, patients have greater expectations that cures can happen if the patient and physician will just persist.

We conclude that short stays do not appear to be a result of Medicare policies. We also conclude that the rapid growth of hospice in the 1990s indicate that overall beneficiaries do not appear to have difficulty accessing hospice.

To preserve access without financially overburdening beneficiaries or taxpayers, Medicare payment rates must be adequate. The rapid growth in providers and service use suggests that rates are not too low on average. However, the industry says rates are too low. We don't know whether the rates are right, too high, or too low. They're based on the hospice demo that was conducted in the early 1980s. The only way to resolve this issue is to reevaluate the rates.

While reevaluating, several payment issues can be addressed. For example, CMS can determine whether rural hospices have higher costs than urban ones. They can also determine whether payment is adequate for shorter lengths of stay. This research could help determine whether case-mix adjustment is needed.

Now we turn to the draft recommendations. Draft recommendation one is on the screen. The Secretary should

evaluate hospice rates to ensure care consistent with efficient providers' cost of providing care. We understand that cost reports will be available in June -- of course, just after our report is due at Congress. And we understand that CMS' staff is chomping at the bit to get at it.

Draft recommendation two, the Secretary should research differences in resources and care needs of patients, and whether a case-mix adjusted payment system for hospice care is feasible.

We welcome your questions and comments.

DR. NEWHOUSE: I think the recommendations are fairly easy to agree with. I would propose, however, an additional one, which is that the Secretary investigate an outlier system. We have considerable heterogeneity in payment at the case level. I guess I should ask Sally whether she considered bringing that recommendation forward or not.

DR. KAPLAN: Yes, we did consider bringing it forward. I think part of the thing that we were concerned about is it seemed like before you reevaluated the rates -- that you didn't want to go jump into an outlier policy until you did that.

DR. NEWHOUSE: Really? I don't see the connection. They're really two different issues I think. The outlier really goes to heterogeneity across patients and the adequacy of the rate just goes to the level of the rate given what the hospice needs to purchase.

MR. HACKBARTH: Would the outlier be an adjunct to a new case-mix system are you saying even --

DR. NEWHOUSE: I see those as independent also. I support investigating a new case-mix system. But it's really inconceivable to me that a new case-mix system could be so good that you would get rid of the heterogeneity across patients.

DR. STOWERS: I just wonder if you have any data -- I would love to have asked Carol this. In my experience, a lot of the non-cancer hospice admissions came out of the home health care system because you take care of that congestive heart failure patient and then they become homebound, and then only at the final stages do we deal more with the hospice. Do you have any data of where the referrals come from, or what track they're coming from?

Because I'm wondering with the proliferation of home health care over the decade that you're talking about, how much substitution here has occurred and might be affecting that short stay in the hospice. I know there's an interaction there because I see it happen every day, but I'm just trying to quantify that somewhat.

DR. KAPLAN: In your mailing material, one of the indicators that predicted short stays -- by short stays, we're changing the definition a little bit: admission within two weeks of death. That indicated that having home health services was a significant predictor of short stays. That also came up among the experts, the people knowledgeable about hospice as well.

The thought was that that might have changed because with the new payment system going from basically a cost-based system

where you paid for as many services as you delivered, to an episode-based payment system, that there might have been a change. Also on the OASIS there is a requirement that the home health agency actually make a prognosis about death. So there's the thought, or at least anecdotally a thought that there's more awareness among home health agencies that people are eligible for and might benefit from hospice.

As far as being able to tell where the folks who are referred to hospice come from, I don't think we can do that in time for April, to tell you the truth. The data is there. It's not the most reliable variable on the claims data, and I think you'd have to do a link-up of home health claims and hospice claims and I don't think we can do that by April.

DR. WAKEFIELD: Actually, it struck me as good news, the statement that we've got fewer than 2 percent of beneficiaries live in areas with no access to hospice care available. I would be interested, however, in knowing how -- and you don't need to tell me now but I'd like to look at how the investigators determined whether or not an area had hospice coverage.

A little bit of what I hear back in my state is that the -- notice I didn't use the word rural, Bob. Back in my state, is that there have been hospice closures but driven in large part by very few patients needing this type of service, long distances to travel to provide it. So I'm trying to reconcile that anecdotal feedback with how they determined what on the face of it is really good news in terms of access to hospice care.

DR. KAPLAN: Chris used various ways of determining that, and I can actually speak to North Dakota. There is a hospice provider who provides services statewide. Chris, first of all, use in a county, any beneficiaries using hospice services in a county, which indicates those services are available. He also used various other indicators. I can't remember what they were, but it was a pretty sophisticated analysis to come up with whether you have hospice available or not in a county.

DR. WAKEFIELD: If I could still see it, that would be just great. Because the person I spoke with is the CEO of a 17-hospital long term care, home health, outpatient, et cetera, delivery system located in the central part of the state and that's what she said to me. So I'd like to reconcile that in my own head with what Chris came up with.

DR. HAYES: We'll nail that down for you. I believe he had access to some industry data on service areas for hospices, self-declared service areas. But we'll clarify that in the next draft.

DR. BRAUN: This is probably not the best time of day, but I notice we often use efficient providers. I was just curious as to how does one determine when a provider is efficient?

DR. KAPLAN: Gee, I wish Julian were here. I don't know how CMS would determine what an absolutely most efficient provider would be, but I think they would very much go by historical information as to how much cost and whether the payments met the costs of providing care for individuals with different

characteristics.

DR. NEWHOUSE: Bea, that's what we do with our update recommendation.

DR. BRAUN: I know.

MR. HACKBARTH: Okay, again, we don't need to vote. I didn't hear any dissent about the two proposed draft recommendations, Joe has offered a third in terms of investigating an outlier independent of the other two recommendations.

DR. NEWHOUSE: Let me note, I think that could probably be put into place faster than a case-mix system also.

MR. HACKBARTH: Any objection to that?

Thank you, Sally, Kevin.